Assimilation into a Therapeutic Community for Substance-Abusing Women

Joni Furlong
Western Kentucky University

Follow this and additional works at: http://digitalcommons.wku.edu/theses
Part of the Sociology Commons, and the Substance Abuse and Addiction Commons

Recommended Citation
http://digitalcommons.wku.edu/theses/396

This Thesis is brought to you for free and open access by TopSCHOLAR®. It has been accepted for inclusion in Masters Theses & Specialist Projects by an authorized administrator of TopSCHOLAR®. For more information, please contact topscholar@wku.edu.
ASSIMILATION INTO A THERAPEUTIC COMMUNITY
FOR SUBSTANCE-ABUSING WOMEN

A Thesis
Presented to the Faculty of the Department of Sociology
Western Kentucky University
Bowling Green, KY 42101

In Partial Fulfillment of the Requirement for the Degree
Master of Arts

By
Joni Furlong

May 2007
ASSIMILATION INTO A THERAPEUTIC COMMUNITY FOR SUBSTANCE-ABUSING WOMEN

Date Recommended April 30, 2007

Director of Thesis

Dean, Graduate Studies May 2007
ACKNOWLEDGEMENTS

I would like to thank the members of my committee for their countless hours of direction, inspiration and support. I specifically want to thank Dr. Steve Groce, Dr. Douglas Smith, and Dr. Anne Onyekwuluje for their patience and understanding. I would also like to thank Dr. Joan Krenzin and her red pen for the guidance in editing multiple drafts.

Thanks to the women, staff, and board of directors of the Flower House. Without their assistance, this project would have been impossible. I wish all of the women of Flower House continued success.

I would also like to thank my fellow graduate students who have cheered me on even when I wanted to quit. Thanks for pushing me forward.

Finally, thanks to my husband Allan and our children, Chris, Kalan and Eli who have had to feed themselves many nights during this process. Their love and support has allowed me to pursue my goals.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Chapter Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>iii</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>v</td>
</tr>
<tr>
<td>CHAPTER I</td>
<td>1</td>
</tr>
<tr>
<td>CHAPTER II LITERATURE REVIEW</td>
<td>5</td>
</tr>
<tr>
<td>CHAPTER III - THEORETICAL PERSPECTIVE</td>
<td>9</td>
</tr>
<tr>
<td>Developing a Sense of Community</td>
<td>10</td>
</tr>
<tr>
<td>Differential Association</td>
<td>12</td>
</tr>
<tr>
<td>CHAPTER IV - RESEARCH METHODS</td>
<td>14</td>
</tr>
<tr>
<td>CHAPTER V - DESCRIPTION AND FINDINGS</td>
<td>17</td>
</tr>
<tr>
<td>CHAPTER VI - DISCUSSION</td>
<td>33</td>
</tr>
<tr>
<td>APPENDIX A RESPONDENT CONSENT FORM</td>
<td>37</td>
</tr>
<tr>
<td>APPENDIX B INTERVIEW GUIDE</td>
<td>39</td>
</tr>
<tr>
<td>APPENDIX C - SYNOPSIS OF INTERVIEWEES</td>
<td>42</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>45</td>
</tr>
</tbody>
</table>
Therapeutic communities provide structure, support and a safe living environment for individuals attempting to recover from addiction. Using peer influence, counseling, education, self-help groups, and case management, they assist residents in conforming to social norms and developing effective coping mechanisms while remaining drug-free. Prior studies have consistently demonstrated the effectiveness of these programs. But, why are they effective for some and not others?

This study explored the residents' backgrounds and the methods employed by them to assimilate into the therapeutic community, the recovering community, and then society at large. The data confirmed my suspicion that the women's ability to conform to social norms and develop effective
coping mechanisms was dependent upon the level of
attachment to prosocial others they attained while in a
therapeutic community. The rules and requirements of Flower
House are designed to promote prosocial attachments and
conformity to social norms. Face-to-face interviews were
conducted with 15 past and present residents of Flower
House, a therapeutic community for substance-abusing women
and their children. These women volunteered to participate.
CHAPTER 1

INTRODUCTION

The effectiveness of therapeutic communities in reducing drug use and criminality has been well documented in several program-based and multi-site evaluations (Messina, Wish, and Nemes 2000). Therapeutic communities are residential settings that assist residents--using peer influence, counseling, education, self-help groups, and case management, in assimilating social norms and developing effective coping mechanisms while remaining drug-free. Participation in therapeutic communities is designed to help people appropriately identify, express, and manage their feelings (Morash, Bynum, and Koons 1998). Like traditional treatment programs, more therapeutic communities are available to men than to women. Of those available to women, only a few provide services to women with children. For instance, in Kentucky there are only three such facilities. This study focused on one of those facilities, Flower House. Flower House is a pseudonym. Residents have been assigned pseudonyms as well to protect their identities and ensure confidentiality.
are chemically dependent and have completed either a 28-day inpatient program or a 12-week, intensive outpatient program. Women are generally referred to Flower House by the criminal justice system or the Department of Protection & Permanency. Residents may bring their dependent children age 12 and younger with them to Flower House if they desire to do so. Flower House is a three-phase program that can be completed in six months. However, many residents remain at Flower House for an average of one year. The focus of this study was to describe the similarities of the residents’ backgrounds and the methods employed to first assimilate into Flower House, then the recovering community, and then the larger society.

Therapeutic communities originated in 1957 with a program called Synanon. Synanon, developed by Charles E. Dederich, consisted of isolating addicts in a therapeutic community where they would learn through confrontational group sessions led by staff and ex-addicts to live drug-free (Kaplan and Broekaert 2003). Although many addicts remained drug-free, the authoritarian style and isolation of addicts from mainstream society led to the dismantling of the organization.
By the mid-1960s a new form of therapeutic community was in existence. These programs, like Synanon, use others recovering from addiction to assist those new to the process in living drug-free. Modern therapeutic communities are residential settings that assist residents--using peer influence, counseling, education, self-help groups, and case management--in assimilating social norms and developing effective coping mechanisms while remaining drug-free (National Institute on... 2005). Unlike Synanon, this new type of therapeutic community focuses on reintegrating the recovering person into society (Kaplan and Broekaert 2003).

By the time women reach Flower House they have engaged in behaviors deemed deviant by society. Most have only been drug and alcohol-free for a month. They often have low self-esteem, trust issues, and a great deal of guilt and shame. What seems normal behavior to these women is unacceptable to society. Thus, they come to Flower House to relearn how to live in society.

This project used qualitative interviews to explore the women’s backgrounds and search for common themes or patterns in their lives that led them to substance abuse. I wanted to discover just how these women, after arriving
at Flower House, managed to become a "part of" or "assimilated" into the community while learning to live drug- and alcohol free lives. I attempted to use sympathetic introspection, placing myself in the place of the residents, to understand them.

Prior studies of therapeutic communities have focused on demographic traits of residents and treatment outcomes, gathering empirical data to demonstrate the effectiveness of this treatment modality (Abell 2004; Ferrari, Jason, Nelson, Curtin-Davis, Marsh, and Smith 1999; Kaplan and Broekaert 2003; Messina et al. 2000). However, my interest lies in why therapeutic communities are effective for some individuals and not others. I propose that success for these residents is dependent not only upon the formal rules of the therapeutic community but also upon the extent to which the resident forms social bonds with others within the therapeutic community.
CHAPTER II

LITERATURE REVIEW

Substance abuse is a major problem that affects every facet of society. Substance abuse contributes to criminality, violence, unemployment, poverty, homelessness, and many other social ills. Men and women sometimes become victims in the vicious cycle of addiction, engaging in inappropriate and sometimes illegal activities. However, research has shown that treatment for substance abuse can offset many of these social ills (National Center on ... 2003).

Most drug treatment programs have been developed by men for men. Even those treatment programs available to women are rarely based on women’s special needs (Hood 2003; Lewis, Haller, Branch, and Ingersoll 1996; Messina, et al. 2000; Richie 2001). Thus, fewer women than men receive any type of drug treatment even when their need is as great as that of men (Hiller, Rowan-Szal, Bartholomew, and Simpson 1996).

Women are more likely than men to have become addicted to drugs at a younger age, to have mental illnesses, and to
have fewer vocational skills (Hills 2004; Messina et al. 2000; Morash, et al. 1998). Like men, women are vulnerable to drug and alcohol abuse and dependence. In 2003 an estimated 5.9 percent of women aged 18 or older met criteria for abuse of or dependence on alcohol or an illicit drug in the past year (National Household Survey ... 2001). Once they start, women tend to become addicted more quickly and to experience negative consequences sooner than men (Messina et al. 2000, Morash et al. 1998).

Differences also exist between women and men that may affect the women’s ability to receive treatment. Women are more likely to have barriers to treatment and are more likely to leave treatment before completion than are men (Messina et al. 2000). For instance, women are normally the caregivers of children and cannot readily find childcare while attending treatment. They usually have fewer financial resources than their male counterparts, making payment for treatment difficult (Lewis et al. 1996; Richie 2001).

Women also experience mental health issues in conjunction with their substance-abuse problems at a higher rate than do men. The presence of mental-health issues often exacerbates the substance-abuse problem and vice
versa (Hills 2004). Thus, retention in treatment for women with co-occurring disorders is lower than that of men (Cacciola, Alterman, McKay, and Rutherford 2001).

Research has shown that women that remain in substance-abuse treatment longer have better outcomes (Grella 1999; Messina et al. 2000; National Institute on ... 2005). Likewise, programs that offer specialized services for women and their children produce better outcomes (Grella 1999; Hughes, Coletti, Neri, Urmann, Stahl, Sicilian, and Anthony 1995; Lewis et al. 1996).

Another problem women face is the availability of treatment programs. Programs that treat co-occurring disorders are scarce, and those that exist often have long waiting periods for admission (Drug and Alcohol... 2002). Too often, after women have made the decision to seek help, treatment is not available (Richie 2001; Sanders and McNeill 1997).

For those men and women that do complete the traditional 28-day inpatient program, returning to their drug-related home environments can be problematic. Therefore, many are referred to residential therapeutic communities.
As previously noted, effectiveness of therapeutic communities in reducing drug use and criminality has been well documented in several program-based and multi-site evaluations (Ferrari, et al. 1999; Kaplan and Broekaert 2003; Messina et al. 2000). Like traditional treatment programs, more therapeutic communities are available to men than to women. Of those available to women, only a few provide services to women with children.
CHAPTER III
THEORETICAL PERSPECTIVE

For the symbolic interactionists, meaning is anchored in behavior. The meaning of an act is neither fixed nor unchanging but is determined by conduct as individuals act towards objects (Meltzer 1972). The self as a social object arises in childhood through interaction with parents and other individuals (Mead 1996). It constantly undergoes change as the individual interacts with others in various situations. Essential to the model of the self is the idea that humans can be objects to themselves (Meltzer 1972).

By the time women reach Flower House, the “self” has not only been formulated by their families of orientation but by the subculture of drug abusers and the labeling processes of society. Women typically come to Flower House with low self-esteem, trust issues, and a great deal of guilt and shame. The behaviors and activities in which they have been engaged are considered deviant by society at large. What has been normal behavior to these women is unacceptable to society. Thus, they come to Flower House to relearn how to live in society.
Developing a Sense of Community

"The term symbolic interaction was first used by Blumer in 1969 explaining that society develops as a result of the interwoven patterns of interaction and action" (Crooks 2001:14). Through interaction with staff and other residents, members of Flower House form a society. In society individual members of a group with a common interest, such as recovering from addiction, develop a sense of belonging (Simmel 1980). Therefore, residents of Flower House develop a sense of community or belonging.

"Human interaction is mediated by the use of symbols, by interpretation, or by ascertaining the meaning of one another’s actions (Blumer 1972, p. 145). Thomas (1978) describes this process as defining the situation. Recovery is as much a process of meaning making as it is the elimination of symptoms (Mancini, Hardiman, and Lawson 2005). That is, in order to know how to behave, a resident must first interpret or give meaning to the actions of her primary group (the other residents). To illustrate, as women enter Flower House, a mentor is assigned to them. On an informal basis, the mentor helps the new resident learn expected behaviors (acts) at Flower House, the language
argot), and gestures. Cooley (1978) asserted that individuals behave the way they perceive others view them. The mentor provides a role model for the new resident to learn the norms of her new environment. Thus, the individual is more aware of himself or herself in action with others. Eventually the individual can conceptualize how he or she should behave based upon the “generalized other” (Mead 1996). Thus, after learning appropriate behavior within Flower House, the residents should be able to internalize that behavior as normative and apply it to society.

Reference groups influence how an individual views himself or herself, his or her environment, and others. These are groups with which one identifies and shares attitudes, beliefs, or ideals and also hopes to join. Inconsistency in behavior may be accounted for in terms of changes in reference groups. This behavior change may be viewed as a collective experience, engaged in by all the members of the group as they act and interpret their world together rather than individually (Becker 1970).

The goal of a therapeutic community is to have residents change their reference groups, thereby resulting in changed behavior. The concept of reference groups may
help account for the choices that individuals make among alternatives, especially if the choice appears to be detrimental to the actor (Shibutani 1972). The new resident will have multiple opportunities to interact with the other residents, the 12-Step community (reference groups), and begin to form social bonds within this closed community.

**Differential Association**

Differential association theory states that behavior is learned through social interaction with others. Children learn how to behave through play. They play roles—mother, teacher, firefighter etc. Children assume roles during play and act out responses to those stimuli (Mead 1996). Role-playing is how the child learns to interpret the actions of others (Blumer 1972). So, it stands to reason that children who become deviant adults have played the role of deviant or at least have been exposed to deviance as normative (Adler and Adler 1989). Coser (1977:131) notes that "for Durkheim, one of the major elements of integration is the extent to which various members interact with one another". It is probable that many of the residents of Flower House were exposed to drug use as normative behavior as children and thus imitated that lifestyle as adults. It is also possible that by exposing the residents to prosocial others
with whom they must interact can promote integration into the therapeutic community.

The goal of this project was to explore the women's backgrounds and search for common themes or patterns in their lives that led them to substance abuse. I also investigated just how these women, after arriving at Flower House, managed to become a "part of" the community while learning to live drug- and alcohol-free lives. It is possible that women exposed to normative behavior through association with prosocial others will adopt that behavior.
CHAPTER IV

RESEARCH METHODS

The purpose of this research was to assess the methods employed by female residents of a therapeutic community in assimilating into their therapeutic community and then society at large. I used qualitative interviews and participant observation. Respondents included 15 past and present residents of Flower House that volunteered to participate. I attended a weekly meeting held for Flower House residents and graduates, presented the research, and asked for volunteers. Residents that expressed interest in participating in this research were scheduled for interviews. Before starting the interview, the attached consent form (Appendix A) was read to the respondent. The respondent was again told the nature of the research, told the types of questions that would be asked and tape recorded, and reminded that participation was totally voluntary. The respondent was also reassured of the confidentiality of her identity. Her signature was then obtained on the consent form.
The 15 women were interviewed over a two-week period and included 13 Caucasians and 2 African-Americans with an age range of 21-50. All but three of the women had children, and one of those was four-and-a-half months pregnant with her first child. Three of the women were graduates of Flower House and had completed the program in 2000, 2004, and recently in 2007. All but four of the women interviewed were referred to Flower House either by the criminal justice system or the Department of Protection & Permanency. The inpatient, substance-abuse programs they had attended prior to entering Flower House referred the four exceptions.

Qualitative interviews (Appendix B) were scheduled at the respondents’ convenience and conducted in a private office within Flower House. Interviews were between 30 and 45 minutes in duration following the consent process. All respondents were given pseudonyms to protect their identities as well as the facility. Appendix C provides a brief synopsis of the women interviewed.

The interview protocol included several questions covering basic sociodemographic characteristics: age, marital status, drug-use history, mental-health problems, family composition and background, educational background
and substance-abuse treatment history. The questions and responses were audiotaped and asked in a conversational style, thereby allowing elaboration. The interview included open-ended responses to previously prepared and emergent themes of inquiry. Major domains in the interview protocol included: a) initiation to drug use; b) past and present family relationships; c) education and employment history; d) criminal history; e) perceived advantages and disadvantages of the therapeutic community; and f) substance-abuse treatment history.

Risks to respondents were minimal. Although due to the sensitive nature of some of the interview questions, respondents may have been reminded of unpleasant emotions. Case managers were and are available at Flower House to address any negative emotions that may arise for respondents.
CHAPTER V

DESCRIPTION & FINDINGS

Flower House is a large two-story brick structure with multiple rooms. It was previously used as a fraternity house and has been renovated to meet the needs of Flower House. There are 18 single bedrooms of varying sizes to accommodate women with children. Flower House is divided into three pods. Each pod has six bedrooms with a full kitchen and bath. The residents of each pod use their pod’s respective facilities.

Approaching the front door of Flower House, one notices the keypad lock on the front door that uses a four-digit code to unlock. The code is changed as residents change. This arrangement is more economical than having locks changed each time a resident leaves. Entering the foyer, where the community phone and a chair are located, one finds the atmosphere quite welcoming. Stairs leading to the second floor are to the left and a staff bedroom is to the immediate right. At the end of the foyer is a small, open room where resident mailboxes, a community bulletin
board, and the sign-in and sign-out sheets are located. The sign-in and sign-out sheets help residents be accountable for their activities outside of the house. They must document the time they are leaving, where they are going, the expected time back, and the actual time back.

To the left of the foyer is the Common Area. The TV/VCR/DVD, two couches, two recliners and coffee table, along with the over-filled bookshelves along one wall, give the room a cozy feeling. This room is where residents gather to just hang out, talk, or watch TV. They are not allowed in each other’s rooms. At the far end of the Common Area is a dry-erase board hanging on the wall with stackable chairs in the corner. This section of the Common Area is used for psycho-educational groups and an in-house Alcoholics Anonymous (AA) meeting. The hallway leaving this area goes to Pod 1 with three of the bedrooms and the kitchen. To the right of the foyer is the medication room that stays locked at all times. The other bedrooms from Pod 1 are located in this area. The playroom is next door to the medication room. It is painted a bright blue with rainbows and flowers on the walls. Painted handprints with past and present children’s names in them are there as
rainbows and flowers on the walls. Painted handprints with past and present children’s names in them are there as well. The room is full of child sized furniture, toys, books, games, and a TV for video games and cartoons. At the end of the hall is the director’s office, which is situated so that staff can see residents as they come and go as well as have a view of the parking lot. Flower House is staffed 24 hours a day by long-term recovering individuals that provide living examples of success for the residents.

Upstairs are two pods, and the layout is the same as downstairs with two hallways. Each Pod has at least two large bedrooms to accommodate children. Residents decorate their rooms and doors. They are not allowed to have TVs in their rooms, and radios and CD players must not disturb other residents. Residents are allowed to use their cell phones between the hours of 7:00 a.m. and 10:00 p.m., after 30 days as long as the ringers are on silent/vibrate. The women sign their phones in and out with staff.

As women enter the program, a mentor is assigned. The mentor is a woman that has been in the house for a while and has at least reached phase two. The mentor will formally orient the new woman to the house, other residents, and house rules and will accompany her any place
outside of the house for the first month she is there. Besides staff, the mentor is the first opportunity for interaction the new resident experiences at Flower House. On an informal basis the mentor helps the new resident learn expected behaviors (acts) at Flower House, the language, and gestures. This interaction is seen as therapeutic by the staff for both the mentor and the new resident. The mentor has already experienced what the new person is now experiencing. That is, she has already served in that role. The mentor can give more assurances that "everything will be alright" than any of the staff ever could. The new resident will also have multiple opportunities to interact with the other residents in the house and the 12 Step community (reference groups) and begin to form relationships within this closed community. The atmosphere of the house is generally familial. Residents tend to assist each other with chores, transportation, therapy assignments, and other duties. It is through these interactions and relationships that the new resident begins to align her actions to the norms of the community.

As previously stated, women typically come to Flower House with low self-esteem, trust issues, and a great deal
of guilt and shame. Many of these attitudes may be attributed to the common theme of unstable relationships, beginning with their parents. An important concept in symbolic interactionism is the definition of the situation. W.I. Thomas and Dorothy Thomas contend “if men [sic] define situations as real, they are real in their consequences” (Thomas and Thomas 1928:572). Individuals will consider the immediate situation, past experience, and anticipate future experiences when deciding on a response or behavior. Several of the women described the environments they were reared in as troubled.

Describe the environment you grew up in?

...my mom, she let my step-dad physically abuse me daily. So it was more like I didn't have parents. I was just in the house being abused all the time. (Rose)

At times it was really good. ...then there were times there was trouble in their marriage, and it was kind of hostile. (Daisy)

Very dysfunctional, alcoholic father, domestic violence, sexual abuse. With dad it was just very scary, very scary. Never knowing what was gonna happen when he got home, if he was gonna beat mama up, uh, just not knowing, hearing the truck pull up and wanting to go outside. It was scary. (Blossom)

I saw a lot of mental and physical abuse. We were dysfunctional. (Iris)
It was--you never really knew what to expect. One minute might be the Beavers. The next it might be the Wild West. You just don't know. (Willow)

...my daddy went out and started shooting drugs, using drugs. My mama, she held on long as she could. She tried to hold us all together, but it just too much for her. Then she went out, and from that I was on my own. At 14 I was pregnant. At 15 I had a baby. At 16 I was pregnant again and had a baby. It went on like that up until I got 20 years old, and I just stopped having babies, and then from that I went to drugs and alcohol. (Clover)

Learning of the women's backgrounds, it is not surprising that they became substance abusers as a way of coping with life. They have mirrored much of their parents' (significant others') behaviors. The majority of the women began using alcohol and/or drugs at a very young age and progressed in their substance abuse rapidly.

How old were you when you first used alcohol or drugs?

Five. What did you use? Vodka. How did your "use" progress? Uh, just from a teenager I would drink at cheerleading practice. I brought vodka to school during cheerleading practice. When I got about 15, I started drinking on the weekend. Then I got pregnant, and I quit. But after my oldest daughter was born, it was just every weekend. By 19 I was doing pills; at 20 I experimented with Meth. It just, it was like every few years I tried something different and like it, and then at the end it was every day all day. (Blossom)

15. What did you use? Alcohol. How did your "use" progress? It went from alcohol to uh, drinking on the weekends in high school, to drinking all the time, to smoking weed, to doing meth, to doing crack, doing pills, doing all of it. (Fern)
13. Well when I was 5, but it was uh, a daily thing, or weekend thing when I was 13. **What did you use?** Smoked marijuana, and uh, drank Early Times and Kessler. **How did your “use” progress?** Went from anywhere from two beers to 12 beers, over the years, and went from one joint to a quarter, went from marijuana to cocaine when I was 17. (Holly)

11. **What did you use?** Alcohol. **How did your “use” progress?** It progressed into first marijuana, then other drugs, stealing my mom's pain medication, sleeping pills, nerve pills, from 11 'til I got sober. (Pansy)

Several of the women had substance-abusing parents, while others believed their parents had placed unreasonable behavioral expectations upon them. None of these women had consistency in their environments, which may have led to trust and self esteem issues.

**How would you describe your self-esteem before entering Flower House?**

Very low, uh, I thought very bad of myself. I practically just thought myself as worthless. Things I had done to myself, uh, I felt like maybe I should've died with all the drug and alcohol I done. I shouldn't be here right now. (Rose)

Very low, which it still is to some degree. (Daisy)

Well, it wasn't completely where it should be, but I wasn't exactly as low as I was when I first got off drugs. (Lily)

Terrible. I didn't have any. (Fern)

Very low. (Violet)
It was very low. I couldn't look people in the eye when I talked to them. I avoided people. I didn't like to have conversations. I felt like everybody was better than me. I was of no importance to anyone. (Ivy)

All but three of the women with children had lost custody of at least one of their children as a direct result of their substance abuse and/or criminal activity. Losing custody of children along with other behaviors substance-abusing women engage in produces a great deal of guilt and shame. Many have engaged in prostitution, stole from their families, friends, and employers, and abandoned their children in the pursuit of drugs and/or alcohol. Thus, the substance abuser continues to use drugs to cope, thereby producing even more guilt and shame. The cycle continues.

**How did you support yourself?**

Beg, borrow, steal. Sold myself. (Pansy)

Um, I used people. I lived off others. I didn't work; others supported me. (Sage)

Any way I could. I sold my body for drugs. I hustled. I stole. I conned my parents out of money. (Daisy)

My family and friends. (Blossom)

Any way that I could. Just by conning people out of money. Uh, saying I needed money to feed my kids or whatever just to get whatever I could. (Violet)
People try to act in ways that are expected of them in different situations. The “self” is born out of social experiences; however, after the “self” is developed, it can continue without the kind of interaction that produced it (Mead [1934] 1962). These women seemed to recreate as adults the environments they had grown up in. For instance, not unlike their parents, these women had been the same drunken/drugged moms to their kids. All of the women described the environments they had lived in prior to coming to Flower House as chaotic. All reported past abusive relationships. Seeking solace and security in drugs, alcohol, and relationships, they found chaos and instability.

**Describe your home environment before coming to Flower House.**

Drugs and alcohol daily. (Rose)

The last place I lived before coming here was on the streets of Louisville. I lived in the missions part of the time and on the streets part of the time. Just drug infested, hostile, and very rough, both physically and mentally. (Daisy)

Sometimes chaotic, but you know it was a house full of love. Didn't always want to be there. (Lily)

It was a using environment. We got high together. (Blossom)

It was a very dangerous place, mostly with drug dealers. (Violet)
I didn't live in a very good environment before going to treatment and prison because of my addiction. I stayed here and there, and I wasn't really around good people, and my environment wasn't safe. I was homeless because of my addiction. (Iris)

One of the goals of Flower House is to bring structure and stability to these women's lives. Upon entering Flower House new residents are immediately paired with more seasoned residents to facilitate the transition. Staff has explained all the requirements, rules, and expectations of the house, but the new resident adjusts better with the assistance of a fellow resident. This observation was evident during the interviews.

**How did other residents or staff try to make you comfortable when you came to Flower House?**

They told me that they were here for me to talk to if I needed someone to talk to, uh, that I could come to them if I had a problem in the house, to let them know if something was bothering me, that this place really wasn't as bad as I was thinking it was. 'Cause I was really thinking it was god awful. (Rose)

I had some of the girls go over the rulebook with me to let me know the rules and stuff, and another one of the girls helped me get to and from my meetings, and they just told me what kind of job I was going into so I'd know what I was going to be doing before I actually got there so that helped a lot. (Lily)

Uh, I got a mentor who helped me get to appointments, meetings, and that helps out a whole lot. (Blossom)
One of the residents, uh, helped me with my daughter when she was sick, helped me with my vehicle when it was all messed up, and just because she cared. She helped with it, uh, told me to hang in there, and told me how much this would help me, and I'm glad I listened because they were right. And staff, they were just really friendly. I was kinda, when I first come here, and I am a timid person, I think. I hate that, but I'm getting better. (Fern)

A couple of the girls, I didn't have any food, I wasn't told that I had to bring anything like that when I came here, so they...they made sure I had something to eat, made sure if I needed anything, that I had it for the first few days before I was able to get out. I was given phone numbers of people to call, taken to meetings. And, if I needed somebody to talk to, the staff was there. (Ivy)

They welcomed me in, they gave me sheets, and they helped me out with stuff that I needed when I didn't have it and rides, and so yea. (Holly)

When a new resident first meets her mentor, she is greeted with a hug. It is a symbolic gesture welcoming her into the community, a way to say "you are wanted and accepted here," which is not the message she received while using drugs. The women hug each other normally before leaving the house and upon returning. Hugging is an appropriate way of validating each other. The residents also frequently share food, clothing, and other items. The atmosphere is familial. The new resident learns from her mentor and other residents how the house operates and how
to organize her time to meet all of her deadlines. She also learns acceptable behavior from the other residents as well as staff.

Both staff and residents mete out informal rewards and punishments for conduct. Flower House provides a structured environment where residents relearn how to adapt to accepted societal norms while remaining drug and alcohol free. All the rules are designed to assist the resident in being responsible for herself and her children. In the beginning the rules are uncomfortable, but eventually residents begin to feel secure within the structure of Flower House.

**Does the structure of Flower House help your in you sobriety? Why?**

Yes, cause the little things is what we need to look at. I mean, the little things is the main things that would get us drunk, like getting angry and getting mad, one argument or make you want to go get drunk. I mean the little things like, if I leave a towel downstairs and I get a restriction, and I get mad about it. If I don't learn how to deal with little things like that, then I ain't gonna never get better. (Holly)

I think so. Because in the beginning, uh, I think without it, when you first get here, when you're first starting out, I don't care how determined you are. I think without those guidelines, the requirements, if we would actually all meet or get to that point. (Willow)

Yes it does. Because, uh, the structure helps me because it's based on AA, and of going back to the
roots. I'm supposed to have a sponsor. So, sponsors is all through the house all the time. I always can come in here and talk to you or, you know, somebody else. (Clover)

Yes it does. I like all the rules. It's a sound environment. It's stable. (Cinnamon)

I know for me, where I come from I didn't follow rules and I needed rules to get my life back in order...the structure of the Flower House. (Sage)

While the residents' mode of sanctions is informal, the sanctions are effective. For instance, a resident that discuss want to go out with friends that continue to use drugs or alcohol may be told point blank that the other women will not want to hang out with her anymore if she does. This peer pressure may be more effective than any formal sanction or therapeutic reaction the staff may use. The new resident begins the assimilation process the first day with a hug and learning how things work in the house. She learns to openly describe how she feels with her fellow residents as trust develops among them. As new residents start to arrive, she begins to take on another role, that of mentor. She will guide new residents in assimilating. In time the new resident has aligned her behaviors to the norms of Flower House, the recovering community, and society at large.
Although not an easy transition, in the end, the women generally appreciate being sent to Flower House. That is, most are coerced into the house by the court system or the Department of Protection & Permanency. However, after living there for awhile, they are happy to be there. They form community with the other residents. They feel safe.

**What do you like most about living at Flower House?**

**Least?**

I like being clean and seeing myself actually trying, trying to do something better for me and my daughter, not just saying I'm going to, not just thinking about it, but I'm actually doing it and I like that.

**Least?** I'm away from my family which is probably good, you know, for me, but I still miss them sometimes. (Fern)

One of the best things about living here is I have my own private room, which allows me some privacy and uh, I like the support I have here.

**Least?** Uh, the fact that I'm 44 years old and I still have to have help. (Daisy)

I feel like I somewhat have my independence where I've not felt like that before. Being able to get on my feet and start a new life.

**Least?** Our work schedule. (Iris)

The unity that I have with some of the girls, uh, understanding that we're here for ourselves and we want this recovery that Flower House has given us.

**Least?** The way that some of the situations are handled, uh, having to be home between 5 and 5:30, that's like right in the middle of everything. Some of the things you get restrictions for is just a little bit ridiculous. (Rose)

The rules and the structure.

**Least?** The rules and the structure. (Violet)
The structured environment of Flower House provides the residents with security, a place to begin to learn to trust and develop healthy relationships. It offers a place for these women to gain self-esteem by becoming responsible citizens. This community allows these women to identify and explore hidden feelings and failed coping mechanisms and to feel loved and supported while doing it. Flower House provides an environment in which seemingly hopeless individuals can find hope again.

However, all residents are not successful in their attempts to begin a new life. The unsuccessful resident is normally one who fails to form relationships with the other residents and staff. She tends to stay in her room, refusing to participate in all but the minimally required activities of Flower House. She is likely to become so dissatisfied that she leaves the therapeutic community and returns to drug use. The successful resident, however, gains hope from the older residents and staff as she forms bonds with them. They have all been in the same situation in which she finds herself. This resident can be found hanging out with the other residents, attending meetings with them, and participating in recreational activities
with her new housemates. She forms relationships. She also learns to trust what the staff tells her because they have walked in her shoes in the past and made it through to a stable life. She begins to believe that a stable life without alcohol and drugs is possible for her.
CHAPTER VI

DISCUSSION

The primary focus of this research was to explore the backgrounds of 15 substance-abusing women that were past and present residents in a therapeutic community and to discover the methods they employed to assimilate into that facility, the recovering community, and then society at large. It is duly noted that such a small sample placed limitations on this research.

Another limitation was my dual role at Flower House. I sometimes found it difficult to remove myself as therapist and be interviewer. I interview the women of Flower House all the time. But, in that case, it is to learn what issues to address and to prioritize them. Attempting qualitative research, I found myself thinking many of the responses in the interviews were just common knowledge. Of course, to me they are. It was a struggle to apply what was of sociological significance, at least on this very small scale, to what I was hearing.

The data did validate the approaches used at Flower House to promote community cohesiveness. The rules and the
structure of the program are all designed to have the new resident become enmeshed in Flower House and the recovering community. Requirements to attend 12 Step meetings, to obtain and maintain employment, to be accountable for their whereabouts, and adhering to set curfews, provide the residents with the structure needed for success in becoming "part of" the recovering community. Although many of the residents balked in the beginning, the majority of those interviewed found the structure of Flower House helpful to their recovery from alcohol and drugs.

The staff realizes that peer pressure is a valuable tool. However, I do not think I ever gave a great deal of thought to the amount of responsibility we place on the mentor. I was aware that this first relationship could be a determining factor of whether a woman adjusted smoothly or not to the house. Relationships with other residents and staff were also significant in how the interviewees learned new roles and expected norms of behavior. In my experience, the women that fail to form relationships and/or bonds with the other residents, tend to leave the program. They are more likely to isolate themselves from the other women, balk at the formal rules and structure of Flower House, and return to drug use. Likewise, those residents that attempt
to maintain antisocial relationships outside of the therapeutic community tend to fail to complete the program.

I was also aware of the commonality in family backgrounds among substance abusers but had never thought of it in sociological terms. That is, I realized how the first significant others in our lives have such an impact on the way we react to the world around us. The women I interviewed had all intentions of never becoming like their parents. However, that is exactly what most of them did. In fact, 7 out of the 12 women with children had lost custody of their children due to their addiction and/or criminal activity. Likewise, several had been in abusive relationships as were their mothers before them. The women tended to recreate the environments in which they had been reared.

Prior to this project I was aware that women usually entered Flower House resistant to the idea and in a short time appeared to have accepted their placement. At some point later women generally either really liked being at the house or were totally dissatisfied. Most of the dissatisfied leave the house and return to drug use or vice versa. In my experience those women that successfully complete the program continue to use the house as a safe
place, as is the case of the graduates interviewed. It is a place to which they can return to talk to staff, gain support, or to assist residents that remain in the house. Each of these changes in attitude is internal and moves at a different pace. That is, there is no way to predict the amount of time it will take a woman to move from one attitude to the next. However, as I observe the women move through these modes, I am aware of the change.

Finally, therapeutic communities work. They assist individuals in learning or in relearning appropriate means of navigating the world without the use of alcohol or drugs. More of these facilities are needed, especially for women with children. Larger, long-term studies need to be conducted to learn how these women continue to assimilate into society at large. I hope that research will continue to show positive outcomes and thereby convince policymakers to fund more such facilities.
APPENDIX A

CONSENT TO ACT AS HUMAN SUBJECT

You consent to serve as a subject in the research investigation entitled: **Assimilation Into a Therapeutic Community for Substance-Abusing Women**. The nature and general purpose of this study is to describe the methods employed by residents of a women's therapeutic community to assimilate into the "house" community and society at-large and has been explained to you by Joni Furlong, from the Western Kentucky University Sociology Department.

You understand the purpose of this research is for a graduate thesis, and that the research procedures involve: review of my chart to gather background information and to track progress; observation of interactions between me, the staff, and other residents; and audio-recorded interviews.

You understand that some of the interview questions that will be asked are very sensitive and personal, including drug and alcohol use, criminal activities, sexual behavior, violence issues, and family relationships. Talking about your past and present situations may be uncomfortable. You understand that you do not have to answer any questions that you do not want to answer.

You understand that your participation is voluntary and that all information is confidential and your identity will not be revealed; you are free to withdraw consent and to discontinue participation in the project at any time; any questions you may have about the project will be answered by the researcher named below or by the Human Protections Administrator for WKU, Phillip E. Myers, telephone 270-745-4652.

Western Kentucky University and the investigator named below have responsibility for ensuring that
participants in research projects conducted under institutional auspices are safeguarded from injury or harm resulting from such participation. If appropriate, the person named below may be contacted for remedy or assistance for any possible consequences from such activities.

On the basis of the above statements, you agree to participate in this project.

Participant's Signature

Joni Furlong
105 Grise Hall
Department of Sociology
Western Kentucky University
Bowling Green, KY 42101
(270)796-1764
APPENDIX B

INTERVIEW GUIDE

*NAME: ____________________________

INTERVIEW DATE: ______/______/______ (M/D/Y)

INTERVIEWER: JONI FURLONG

TIME BEGUN: ________________ TIME ENDED: ______________

1. What is your birth date? ______/______/______(M/D/Y)

2. Of which ethnic group do you consider yourself a member?

3. What is the highest grade of school you have completed?

4. What is your current marital status?

5. Are you satisfied with your current marital situation? Why?

6. Do you have children? If yes, how many and where are they? How do you feel about being separated from your children? OR

7. Are you now living with any of your children?

8. How many children under 13 years of age are living with you?

9. Do you have a valid driver's license?

10. Do you have an automobile available for use?
11. Were you working before coming to Flower House? If yes, where? If no, how did you support yourself?

12. Do you have a job now? How do you feel about it?

13. Prior to living at Flower House, where did you live? With whom?

14. Describe the environment?

15. What did you like most about where you lived? Least?

16. Whom did you live with while growing up?

17. Describe the environment?

18. Describe your relationship with your parents as a child? Now?

19. What is your most significant childhood memory? Why?

20. Did either of your parents have a problem with alcohol or drugs?

21. If yes, how did that affect you?

22. How would you describe your self-esteem before entering Flower House?

23. How would you describe your self-esteem now?

24. Why do you think it changed? (If respondent expressed a change above)

25. How old were you when you first used alcohol or drugs?

26. What did you use?

27. How did your “use” progress?

28. How did your family react when they found out you were using drugs? Friends?

29. How many times have you been in substance-abuse treatment? Was it inpatient, outpatient, self-help?
30. Have you ever been treated for emotional or mental health issues? If yes, what?

31. Who referred you to Flower House? Why?

32. What Phase are you in? How long have you been at Flower House?

33. How would you describe Flower House? Why?

34. Do you feel comfortable living at Flower House? Why, why not?

35. When you were first admitted to Flower House, how did you feel about living in the house?

36. Has that changed? How?

37. How do you feel about the other residents? The staff?

38. Is that different from the way you felt about them when you first came to Flower House? How?

39. How did other residents or staff try to make you comfortable when you came to Flower House?

40. Did it help? How?

41. How do you feel about the rules and requirements of Flower House? Why?

42. Does the structure of Flower House help you in your sobriety? Why?

43. What do you like most about living at Flower House? Least?

44. How long do you plan to stay at Flower House? Was that your original plan?

45. What are your plans when you leave?

46. Is there anything else about living in Flower House that I haven’t asked that you’d like to tell me?
APPENDIX C

SYNOPSIS OF INTERVIEWEES

Rose - 21 year old single, white female without children referred to Flower House by the criminal-justice system. She has been at Flower House for two months.

Daisy - 44 year old divorced, white female referred by the inpatient treatment facility she attended. She has two children ages 19 and 22. She has been at Flower House for four months.

Lily - 23 year old divorced, white female, pregnant with her first child. She was referred to Flower House by the criminal-justice system. She has been at Flower House for almost three months.

Blossom - 32 year old separated, white female with two children ages 14 and 8 that are currently in their maternal grandmother's custody. She was referred by the criminal-justice system. She has been at Flower House for two weeks.

Fern - 32 year old separated, white female who has her one year old daughter with her at Flower House. She was referred by the inpatient treatment program that she attended. She has been at Flower House for almost two months.

Violet - 30 year old married, white female that graduated from the program in February 2007. She was referred by the criminal-justice system. She has two daughters ages 10 and 4. One child lives with the paternal grandmother and the other with a paternal aunt. She stayed at Flower House for almost 15 months.

Ivy - 32 year old divorced, white female referred by the Department of Protection & Permanency. She has four children ages 8, 8, 4 and 2. The older two children are
with their dad and the younger two are with a cousin. She has been at Flower House for almost four months.

**Iris** - 37 year old separated, white female with three children ages 20, 17 and 16. Her 20 year old is in college, and the other two are with their dad. She was paroled to Flower House from Otter Creek Prison for Women. She has been at Flower House for two-and-one-half months.

**Tulip** - 30 year old divorced, white female who has her two year old daughter with her. She was referred by the inpatient treatment program she attended. She has been at Flower House for two months.

**Pansy** - 48 year old divorced, white female with four adult children. She was referred to Flower House by the criminal-justice system. She graduated from the program in August 2000 and has been clean and sober for seven-and-one-half years. She was a resident of Flower House for seven months and one week.

**Holly** - 27 year old single, African-American female who has her four children with her, ages 9, 8, 3 and 5 months. She was referred by the criminal-justice system. She recently returned to Flower House, following a relapse, after being discharged for two weeks. She was at Flower House for almost five months before the relapse, discharged for two weeks, and has been back in the program for three weeks.

**Willow** - 35 year old divorced, white female with four children. She has her 12 year old daughter with her, one adult son in New York, and two other sons in the custody of their maternal uncle. She was paroled to Flower House and has been a resident for two-and-one-half months.

**Clover** - 43 year old single, African-American female with five adult children. She was referred by the criminal-justice system and has been at Flower House for four-and-one-half months.

**Cinnamon** - 50 year old married, white female with three children ages 35, 19 and 15. The two youngest are with their dad. She was referred by the criminal-justice system and has been at Flower House for three months.
Sage - 31 year old single, white female. She was referred by the inpatient treatment program she attended. She graduated from the program in September 2004 and has been clean and sober for two-and-one-half years. She resided at Flower House for 11 months.
REFERENCES


Sanders, Jeanette F. and Kevin F. McNeill. 1997. "The Incarcerated Female Felon and Substance Abuse Demographics,


